System Leadership Council: December 7 Meeting Summary

General Business

- The following members attended the third meeting of the System Leadership Council:

Janet Areson	Richard E. Kellogg	Julie A. Stanley
Charline A. Davidson	Larry L. Latham, Ph.D.	Frank L. Tetrick, III
Virginia Dofflemyer	Cathleen J. Newbanks	William J. Thomas
Brent Frank	Raymond R. Ratke	James A. Thur
Paul R. Gilding		

- Council members reviewed the November meeting summary and no changes were made to it.

Department's Technical Assistance Philosophy

- Generally, the Department's philosophy is that it should not provide technical assistance about activities that it regulates or in which it has a fiduciary responsibility, because there may be adversarial situations around accountability.

- However, sometimes the Department may need to provide orientation or training about some activities, particularly new ones. For example, the new Human Rights Regulations are so complex that it will be important for the Department to offer training on implementing them. The Commissioner suggested that, in the future, perhaps the program offices would be involved in more specific technical assistance, like the specific technical assistance staff are providing for the new mental health children's services.

- For example, he would like to see the Department provide resources for targeted efforts to move forward with standardized practices for psychosocial rehabilitation. There will be problems down the road if community psychosocial rehabilitation services are not connected to those being offered in state facilities. Psychosocial rehabilitation in state facilities is so different from and more intensive than many community psychosocial programs that patients risk regressing or losing their progress achieved in state facility programs.

- He commended CSB and state facility staff involved in the effort at Central State Hospital to develop standardized predischarge planning process practices and documentation and suggested that this could be replicated across the rest of the state. He concluded that the Department is more than willing to provide training on specific issues and programs.

- Ms. Dofflemyer added that the State Board is very concerned about the lack of commonality across CSBs. She noted that the State Board would like to see this issue addressed.

- The Commissioner noted that there seem to be aspects of dependence, co-dependence, and independence related to technical assistance issues. CSBs want to be independent, receive the state funds, and do good things locally. This probably worked well when the system was small and without much visibility. Now, the system is large and highly visible.

- Historically, the Department's relationship with state facilities is more direct than its more ambiguous relationship with CSBs. However, the General Assembly has added structure to the CSB relationship through the law (HB 428), as has Medicaid, which has moved the relationship much more into a market arena. He noted that he has observed a general hesitancy among CSBs to embrace this role; however, there is no way that the market orientation will not increase over time.

- A member indicated that he has described his CSB as the community arm of the services system, as the state facilities are the institutional arm of the system. This implies some interdependence, despite the historical rhetoric of independence. He suggested that there may be some desire among CSBs to clarify their ambiguous relationship with the Department. Another CSB representative agreed and suggested that the Department has a tremendous opportunity to share information among all CSBs, providing guidance and technical assistance regarding quality improvement from its overall perspective across the 40 CSBs.

- Another member raised questions about boundaries of authority and accountability between the Department and the 40 CSBs. The Commissioner replied that this is a complex area; the Code of Virginia is silent. The Department is highly dependent on CSBs to care for individuals with serious mental illnesses and mental retardation, who might otherwise be admitted to state facilities. He noted that this has been a strength of the system, and he always has complimented CSBs on their success in decreasing admissions to state facilities. There is a somewhat differential situation regarding substance abuse, since persons with a primary diagnosis of substance abuse should be served in community settings, not in state facilities.

- The Commissioner described several examples of dependent or co-dependent behavior between the Department and CSBs during recent months. The VACSB was supporting a budget request for an additional $250,000 this year for Part C, to cover possible shortfalls. The Commissioner, who is the Chairman of the VICC, did not hear about this from the VACSB directly. However, after he learned about the request and the situation, he made additional federal funds available. If he had known about this situation earlier, it could have been addressed without proposing a budget amendment. Another example is the VACSB's MR waiting list, which for years has hovered around 5,000 individuals. DMAS has identified only 1,100 cases, half of whom were added in the past six months. Historically, similar numbers confusion has hurt the VACSB's credibility. These examples were cited only to describe the reality of the co-dependence or dependence between the Department and the CSBs.

- He concluded that the Department and CSBs are dependent on each other; but, at critical points of accountability, they are independent. At various times, these relationships are dependent, co-dependent, or independent, and, in real time, there are few opportunities to negotiate role shifts. Another member observed that this situation would be simpler without the complicating factor of DMAS, which perceives a complete lack of responsiveness from CSBs on the choice issue.

- The Commissioner observed that there is often a sense of loss associated with change, even when you benefit from the change. He suggested that CSBs have been feeling a sense of great loss, even while there have been lots of improvement and progress, and that the only way to move ahead is to resolve that sense of loss.
- Organizations generally do not like or embrace change. It is harder now to be a CSB executive

director than it was years ago, because you have to manage more of your money on a non-program basis (e.g., Medicaid, individualized purchases of services, special projects).

- All health care systems are dealing with similar dynamics. Large hospitals are combining into health systems while retaining their identities, standardizing with flexibility. This is being done in response to changes in payment systems and third generation managed care.

Uniform Community Clinical Care Policies and Procedures/MR Case Management

- Ray Ratke mentioned that the VACSB MH Council was working with Jim Martinez and others in the Department on service models. He noted that group has taken some System Leadership Council ideas and moved beyond them. He reported that the MH Council is very enthused about this effort and the VACSB Executive Directors Forum voted to support this approach. The Commissioner commended these efforts.

- The group discussed the service model handout.

    - The Commissioner noted that the MH model is very attractive, but he expressed a concern about guiding principle 4. The Department, through the performance contract, has the responsibility to set standards. While the Department wants to do this collegially, standards should not be seen as voluntary.

    - He feels pressed to push psychosocial rehabilitation standardization now, given the paradigm being implemented in state facilities, but he recognizes this needs to be a collegial process. Ray Ratke noted that we've already agreed in the performance contract to work on this together.

    - **The Commissioner agreed that Department staff would develop a response and a time line and process that we can all use publicly for this effort.**

    - A concern was raised about principle 7. Rather than linking implementation to available resources, we should adopt a phased implementation schedule. The goal is to achieve the standard or model over time, but to begin implementation now. The Commissioner shared this concern, noting that the Department encountered the same perspective with some state facilities' reaction to its standardization initiative. He suggested that organizations can look within and redeploy existing resources if the priority is high enough.

    - There was a suggestion to change "will require" to "may require" and mention possible redeployment of resources in principle no. 7.

    - The Commissioner repeated his concern from the previous meeting about some CSBs with large budgets and high consumer to psychiatric FTE ratios not redeploying some resources to address this situation. For instance, if a CSB still offers outpatient services to persons who are not seriously mentally ill and it has a very high consumer to psychiatric FTE ratio, the CSB should redeploy existing resources to address this critical need.
    - The Department has avoided taking a hard line on medical issues with CSBs, instead using a measured approach. However, the Commissioner noted that if a CSB does not have

adequate medication management today, it should not be in the business.

- Virginia Dofflemyer stated that local communities have to realize that the state cannot carry the whole burden; local governments in some parts of the state need to provide more money for this to be a state-local partnership. Janet Areson observed that Virginia needs to revise its local tax structure so that local governments could be able to do this.

- The Commissioner noted that there will be a time, perhaps in a year, when the Department will be more definitive on several clinical issues and about how resources are used.

- Larry Latham suggested that, based on the group's discussion, function will dictate form. He noted that, in implementing the standardization Department Instructions, state facilities have inevitably altered their structures. He observed that we seem repeatedly to confuse structure and function in considering Department-CSB relationships.

- He noted that, as the Region 4 CSBs implemented local acute inpatient care, this fundamentally altered CSB relationships with the state facility and the Department. He characterized the recent meeting with Region 4 CSBs about predischarge planning as one of the more productive meetings that he has been involved in. The group identified the following division of labor around predischarge planning.

  - The state facility is principally responsible for identifying the patient's needs.
  - The CSBs are primarily responsible for identifying services in the community to meet those needs.

- He noted that this will require creative approaches (e.g., state of the art psychosocial rehabilitation rather than the old clubhouse model) for particular patients.

- He suggested that the Code changes regarding predischarge planning were too narrow. He observed that most people being admitted to state facilities are known to everyone and should arrive with a predischarge or preliminary discharge plan that would guide their treatment while in the state facility.

- An overall theme emerged: policy and procedural uniformity will lead to fundamental changes in how things are done. This was linked to the progressive quality improvement approach, that was implemented initially at the Northern Virginia Mental Health Institute, then Central State Hospital, and will be put in place at all state facilities.

- The Commissioner noted that the Governor or the General Assembly appear to have no desire to make significant structural changes in the community system. Instead, there may be more of a focus on operational improvements. He suggested that the HB 428 predischarge planning changes stemmed from a perception, right or wrong, that CSBs did not take responsibility for their consumers in state facilities. He stated that the time has come to license case management.

MR Waiver, Consumer Choice, and Provider Access Issues

- Several members raised concerns about the focus on funding emergencies, rather than looking at

meeting other needs as well. One member questioned if there was still an interest in carrying out the fundamental responsibility of government to care for individuals with mental retardation.

- The Commissioner reviewed events of the last two years related to the waiver, starting with the $40 million appropriated for additional waiver slots. He cited the following factors that led to where we are today:

  - a convergence of structural issues in the original waiver,
  - a new generation of advocates,
  - the transfer of match responsibilities from the Department to DMAS, and
  - HCFA concerns about Virginia compliance (e.g., state wideness, choice).

- The state had no policy between July 1 and August 24 last year, and this engendered the concerns that emerged among families and advocates.

- He reviewed the activities of the MR Waiver Advisory Committee, noting that the meeting in the preceding week was the best dialogue about people with mental retardation and the waiver since he has been in Virginia. That meeting was difficult for CSB representatives because they had to deal with parents with whom they had not dealt before, individuals who are not from the traditional advocacy community. These parents have serious, heartfelt concerns.

- There are lots of opinions about how the waiver should operate. He indicated that he thought brokering would be separated from case management. DMAS has been told that HCFA believes Virginia has problems with choice and access to providers.

- While the current waiver is in a real state of ambiguity, the Governor wants a new waiver by July 1, 2001.

- CSBs are in a difficult position. They appear to be defending the status quo, while the trend in the advocacy community is self-direction and increased choices.

- A member representing CSBs suggested that self-determination works well for people with physical disabilities, but less well for people with cognitive disabilities. He noted that parents in his jurisdictions are very concerned about health and safety issues, which case managers are responsible for. He also contended that if case management were decentralized and not left with CSBs, the quality of care would suffer.

- The Commissioner agreed that health and safety concerns are of the highest important. He indicated that his consistent policy position is that quality assurance occurs through case management at an individual consumer level. He also suggested that there will be more oversight of severity (the level of consumer functioning and eligibility for the waiver) and cost of services in the waiver.

- It was noted that, in Northern Virginia, Medicaid rates are so low they affect the quality of care.

- DMAS has acknowledged that three rates need to increase, but case management may be reduced and the unit changed. DMAS will not respond to caseloads and rates because case

management is not capitated, it is reimbursed on a fee-for-service basis.

- The Commissioner reviewed the independent broker proposal presented to the Advisory Committee by Jessica Burmester and Tessa Shuk. The broker would be an independent entity or professional who would work with the consumer and family, educating and working with them about the waiver and choices. The independent broker would work with the case manager about alternatives and would have no investment in the consumer's or family's choices. The case manager would be responsible for assuring the plan is appropriate and the consumer is protected.

- There also are some strong feelings about care coordination on the Advisory Committee. A number of members want choice and entry into the system to be separated.

- A member representing CSBs observed that the independent broker looks like an overly layered system with overlapping responsibilities. The Commissioner suggested that if CSBs have an alternative model, they should be ready to present it at the next Advisory Committee meeting. However, he cautioned that the Lubbock model would be rejected. He also advised against opposing independent brokers. DMAS and HCFA, in addition to family representatives on the Advisory Committee, like independent brokers.

- Another CSB representative asked if, as private providers became more involved in the services system, would the Department apply its standards of care and quality improvement requirements to them? Otherwise, we could end up with two different systems of care for the same population.
- The Commissioner noted that licensing and human rights requirements apply to private providers too; but he agreed that this was an important point. The goal would be to treat all providers equitably. For instance, it would be the Department's goal to include private providers in POMS, using public funds to support this, as the Department has done with CSBs.

- He agreed that this was a relevant public policy matter that should be discussed further. Also, as DMAS has become a major payor for and contractor of services, the issue of disparity between DMAS and Departmental accountability requirements should be addressed. As a principle, the private sector should have the same accountability requirements as the public sector. Some private providers reportedly are saying that they would be willing to do this if they had access to the same funds under the same conditions as CSBs.

- The Commissioner suggested that accountability of the private sector to CSBs is in place now through local contractual mechanisms.

- It's clear that the DMAS data system will change, probably not until the next administration, and it will include encounter data.

- He suggested that the single point of entry into the system has always been a misnomer. CSBs are the single point of entry into the state facility system, and this has been very valuable for the system.

Data Management

- The Department has agreed to look at streamlining the performance contract and reports where possible. This will be reflected in the SFY 2002 performance contract exposure draft.

- The Department is committed to streamlining and standardizing data requests. The Department is working with the VACSB Data Management Committee and is partially funding Joan Durman to identify and categorize all CSB data and reporting requirements.

- The group agreed that the Department should code all of its data requests uniformly and consistently, using a standardized data set like the ICDE. The Commissioner mentioned that he might be establishing a data czar in the Department to assure more uniformity and consistency.

- The Commissioner indicated that the Department is willing to continue a public dialogue about equity between the public and private sectors regarding accountability so that the services system appears seamless to consumers.

- He indicated that he would support funds for a standardized data platform, but not incremental funds for a decentralized approach.

Performance Contract

- Paul Gilding briefly reviewed the development of the SFY 2002 performance contract exposure draft, which the Department will circulate for a 60 day public comment on January 1, 2001.

- Ray Ratke mentioned that he has 12 to 15 names of people interested in working on the jail survey, including juvenile detention facilities.

Comprehensive Plan for Restructuring Virginia's Mental Health Care Programs and Facilities

- The Commissioner reported that Louis Rossiter, Ph.D., Deputy Secretary for Health and Human Resources, and he met recently with Mary Ann Bergeron, Ray Ratke, and Michael O'Connor to discuss the restructuring plan. Its major features include:

    - acute inpatient care in the community with a limited capacity retained at state facilities,
    - a new gero-psychiatric residential service that would be more intense than nursing homes but less intensive than state geriatric facilities,
    - re-engineering the DeJarnette Center to serve Comprehensive Services Act children and adolescents with community resources for non-CSA youth,
    - a two, four, and six year implementation schedule, and
    - base state facility budget resources moved to the community.

- Dr. Rossiter described the plan as a reaffirmation of the community services system, noting that the plan is predicated on the strengths of the community services system.

Next Meeting

- The Council's next meeting will be on February 15, 2001 at 10:00 a.m. Subsequently, this date was changed to March 9, 2001.

- **Tentative Agenda**

    - Review of December 7 Meeting Summary
    - MR Waiver
    - Legislative Issues
    - Restructuring Plan Update